STATE OF NEBRASKA - ONLY FOR LABORATORIES LOCATED IN NEBRASKA

NEBRASKA CLIA CHANGE FORM ***(Complete Only the Applicable Area)***

This form may be completed online, printed and mailed to the address listed below.

CLIA NUMBER_____ DATE_____

Laboratory Name_____

Laboratories are to make notification within 30 days of the following changes:

1. **OWNERSHIP**

   New Owner_____

   Effective Date_____ FTIN Number_____

   *****Need to also complete HCFA-1513 Disclosure of Ownership Form*****

2. **NAME**

   New Name of Facility_____

   Effective Date_____

3. **LOCATION**

   New Address_____

   Phone Number Change? New Number _____

4. **DIRECTOR**

   New Director Name_____

   Effective Date_____

5. **APPLICATION TYPE CHANGE**

   Currently certified as: ____ Regular ____ Waived ____ Accredited ____ PPM
   Proposed certified as: ____ Regular ____ Waived ____ Accredited ____ PPM

   Effective Date for the above application type change: _____

   If changing to Accredited certification please indicate the accrediting agency:
   ____ **JCAHO** ____ **COLA** ____ **AABB** ____ **CAP** ____ **ASC** ____ **AOA** ____ **ASHI**
   Other (specify) _____

****NOTE* If changing certificate type to an accredited certificate, attach documentation from the accrediting agency that you are enrolled.***

For application type changes, please complete the back side of this sheet, indicating the tests that are being performed and the volumes for each test.

6. **LABORATORY CLOSED** Effective Date: _____

SIGNATURE VALIDATING CHANGES: _____

PLEASE RETURN THIS FORM TO:

JOANN ERICKSON, RN
PROGRAM MANAGER
CREDENTIALING DIVISION-FACILITIES
PO BOX 94986
LINCOLN, NE 68509-4986

or FAX to (402) 471-0555

FOR DEPARTMENT USE ONLY: CREDENTIALING/LABS 7/02

Changes made for: Ownership _____ Name _____ Location _____
Closed _____ Director_____ App. Type change _____
Date made_____ Changes made by _____ ACO _____

LIST OF TESTS PERFORMED
(including Waived and PPM)

LAB NAME _____

ADDRESS _____ CITY/ZIP _____

CLIA NO. _____ CERTIFICATE TYPE* _____

NEW APPLICANTS – PLEASE READ: Please list the manufacturer's name and model of the instrument or manufacturer's name of the test kit used for patient testing. For example, do not list "Hematology machine or Strep Kit". This will ensure that you will receive the correct certificate based on the tests performed in your laboratory.

TEST	METHOD	SPECIALTY/SUBSPECIALTY	ANNUAL VOLUME
EXAMPLE: **POTASSIUM**	**KODAK DT60**	**CHEMISTRY**	**50**

*Types of Certificates are: Certificate, Certificate of Accreditation, Certificate of Provider-Performed Microscopy, Certificate of Waiver.

SIGNATURE _____ DATE _____

LABCERT 1/00